Seminole Nation Diabetes Summer Youth Camp
Physician Referral Form
Deadline July 3rd, 2014

This form must be completed and signed by both the referring physician and consenting parent/guardian and returned prior to camp registration

PLEASE PRINT

Name of Camper: _____

Date of Birth ____/____/_____ Gender: Male/Female Age: _____

Name of Parent/Guardian: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: (_____) _____-_____

Alternative Number: (_____) _____-_____

Emergency Contacts in Case Parent/Guardian Unavailable:

1. Name/relation to camper_____ Phone: (_____) _____-_____

2. Name/relation to camper_____Phone: (_____) _____-_____

[OFFICE USE ONLY]
Body Mass Index (BMI)
BMI Calculation: [weight in pounds/ (height in inches²] x 703

Camper's Weight (lbs):_____ Camper's Height (in): _____

BMI: _____ BMI Percentile: _____

Immunization History: (Please include dates)

DTP Series:	Yes / No	Date: _____/_____/_____
Measles:	Yes / No	Date: _____/_____/_____
Tetanus:	Yes / No	Date: _____/_____/_____
Chicken Pox:	Yes / No	Date: _____/_____/_____
Meningitis:	Yes / No	Date: _____/_____/_____

Health History

Please check all that apply and provide explanation if needed:

*****Campers with the following conditions must provide a physician's clearance letter in addition to this completed form*****

Asthma: _____
Ear Infections: _____
Headaches/Migraines: _____
Seizure Disorder: _____
Heart Condition: _____
Diabetes: _____
Blood Disorder: _____

Behavioral Disorder: _____
Dizziness/Fainting Spells: _____
Thyroid Problems: _____
Kidney Disease: _____
Injuries to bones/joints: _____
High Blood Pressure: _____
Sleep Disorder: _____

Comments: _____

_____

_____

Allergies

Please check all that apply and provide explanation if needed:

_____Food Allergies
Please list: _____

_____Drug Allergies
Please list: _____

_____Insect Allergies (Ex. Bee stings, wasp stings, etc.)

_____Seasonal Allergies

_____Other Allergies
Please list: _____

Does your child carry an Epi Pen? Yes/No

Medications camper is currently taking:

Drug	Dosage	Times/Day	How long?

Has the camper ever had any serious injuries/medical conditions? Yes / No
If yes, please list and provide a brief explanation:

_____

_____

Restrictions/Limitations while at this camp: (please be specific)

_____

_____

Physician Name: _____ Specialty: _____

Date: _____/_____/_____

Signature of Physician: _____

Phone (_____) _____-_____

Parent/Guardian Authorization:

I (parent/guardian) _____, agree that this health history information is correct and the person herein described has my permission to engage in all camp activities, with the exception of any restrictions/limitations as described. In the event that I can not be reached in an emergency, I hereby give permission to the medical personnel to secure proper treatment for, hospitalize, and to order injections, anesthesia or surgery for my child as named above.

Signature of Parent/Guardian: _____ Date: _____/_____/_____

Please send completed form with application to:
Seminole Nation Diabetes Program
Attention: Deborah Ferguson
P.O. Box 1498
Wewoka, OK 74884-1498
Email: ferguson.d@sno-nsn.gov